NEW ❒

AUDIT ❒

AGENT# _____

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS
600 WASHINGTON STREET - 7TH FLOOR, BOSTON, MA 02111
(617) 727-4900

APPLICATION FOR APPROVAL
UTILIZATION REVIEW AND QUALITY ASSESSMENT PROGRAM ("PROGRAM")
452CMR 6.00 *et seq*.

I. **CORPORATE & SITE DEMOGRAPHICS** *A separate application must be complete for each site within the organization/corporation conducting utilization review(UR) for the Massachusetts Workers's Compensation Program. Each site will be approved as a separate UR Agent within the organization/corporation.*

In the spaces below, identify Name of agent, **site** and street address **(Post Office Boxes are not acceptable for certificates**) as it should appear on the approved certificate. Please note that the street address for a particular site may be different than the mailing address. List the site's DIA certificate number if previously approved. Company name, including "doing business as" ("dab") must be supported by articles of incorporation or other legal documentation submitted with application. The name listed here must be consistent with the primary name of applicant company. If you want to use other corporate names on your certificate, you must submit with your application the appropriate legal documentation for such other corporate names. The information in sections A, B, D, (#2 and 3 only) will be included in a list made public by the Department of Industrial Accidents ("Department").

A. Name of Applicant: _____

B. Name of the Program or D.B.A.: _____

C. FEIN #: _____

D. Applicant's Program contact(s):

1. The Program's Corporate Contact:
   a) Name: _____
   b) Title: _____
   c) Address: _____
   d) **Telephone:** _____ e) **Fax:** _____
   f) **Toll-Free #:** _____ g) **Email:** _____
2. The Program's Massachusetts Contact:
   a) Name: _____
   b) Title: _____
   c) Address: _____
   d) **Telephone:** _____ e) **Fax:** _____
   f) **Toll-Free #:** _____ g) **Email:** _____
3. The Program's Public Contact:
   a) Name: _____
   b) Title: _____
   c) Address: _____
   d) **Telephone:** _____ e) **Fax:** _____
   f) **Toll-Free #:** _____ g) **Email:** _____
4. Toll free telephone number for the Program (to be provided to injured employees):

_____

Exhibit A

Has the applicant been approved to perform Utilization Review for workers' compensation in other states?

☐ Yes; list state(s) ☐ No

II. TREATMENT GUIDELINES & REVIEW CRITERIA:

A. The applicant will use the Health Care Services Board ("HCSB") endorsed Treatment Guidelines and the Department's Review Criteria for all conditions where they apply?

☐ Yes ☐ No

B. Identify all secondary sources of treatment guideline(s) to be used for medical conditions not covered by HCSB-endorsed Treatment Guidelines:

1. ☐ Proprietary/commercial: _____
2. ☐ Public, state or federal agency: _____
3. ☐ Professional associations: _____
4. ☐ Internally derived treatment guidelines: _____
5. ☐ Other: _____

C. Identify all secondary sources for review criteria used to review medical conditions not covered by HCSB-endorsed Treatment Guidelines:

1. ☐ Proprietary/commercial: _____
2. ☐ Public, state or federal agency: _____
3. ☐ Professional associations: _____
4. ☐ Internally derived review criteria: _____
5. ☐ Other: _____

Exhibit B

Describe how the applicant's internally derived treatment guideline(s) and review criteria are developed and revised, including:

1. The role of the medically qualified Practitioner(s) who is/are involved in the development of the internally derived treatment guideline(s) and review criteria;

2. Internally derived treatment guideline(s) and review criteria shall be maintained in a format similar to the format of the HCSB guidelines and review criteria.

3. Internally derived treatment guideline(s) and review criteria shall be reviewed and necessary revisions made at least annually.

4. Internally derived treatment guidelines shall be developed through the use of clinically based literature and scientific research.

Exhibit C

Describe how each of the secondary sources above will be applied to review the treatment of injured employees.

III. REVIEW PROGRAM:

Exhibit D

Attach flow charts and a detailed narrative of the applicant's procedures for conducting prospective, concurrent, and retrospective UR from initial request through final complaint to DIA. *Incorporate the Departments' recommended clinical procedures relating to clinical review time frames for each type of review and collection of additional information. (Recommended clinical review procedures available on the Departments web site* www.state.ma.us/dia *see the OHP link to the application).*

Exhibit E

A. Describe the process for notification of adverse determinations to the ordering practitioner and injured employee/representative.

B. Provide a detailed description of the adverse determination process that includes both the HCSB treatment guidelines and review criteria applied by the applicant and the clinical rational for reaching the determination.

Exhibit F

Provide a detailed description and flow charts of both standard and expedited appeal procedures by which an ordering practitioner and/or injured employee may seek review of the applicant's utilization review determination(s).

Exhibit G

Provide a detailed description of the applicant's internal quality assessment and monitoring process, and how it will evaluate and measure the quality of its Program. Provide any and all internal or external audit processes of the determinations made by all level reviewers including subcontractors. 2) Provide list of all licensed reviewers their license number and category, state of licensure, expiration date, and letter of attesting to number of hrs in active practice. 3) Provide an outline of formal training requirements for each level of clinical reviewer and administrative staff. 4) Provide policies and procedures regarding documentation of the review process, (case notes and summaries, referral forms etc.). 5) Provide a copy of organizational flow chart for the utilization management department indicating reporting/supervisory relationships, corporate organizational chart, and table of sub-specialties of clinical reviewers. 6) Provide a copy of your grievance/complaint procedures for injured employees (a copy of any grievance/complaint received by the UR agent must be forwarded to the DIA OHP within ten days of its receipt).

A. Does the applicant have written/printed materials used in marketing, advertising and promoting its program to employers, insurers and others?

☐ Yes – please attach samples ☐ No

B. Does the applicant provide additional services, other than those approved by the Department, as part of the applicant's business?

☐ Yes – *List all additional services provided and provide a detailed narrative description of how these services are delineated from the applicant's utilization review program. (other than MA WC UR and claims)* ☐ No

C. Will the applicant provide any economic incentive(s) to achieve cost savings in its program?

☐ Yes - Explain ☐ No

D. Case management is considered an ancillary service in Massachusetts Workers' Compensation. If case management services are provided, the applicant agrees that clinical reviewers will not conduct case management of the same case(s) they are providing utilization review.

☐ Yes ☐ No – Explain

IV. UTILIZATION REVIEW NOTIFICATIONS, DETERMINATIONS AND APPEAL PROCEDURES:

Exhibit H

A. Provide clearly marked sample copies of the letters (on business letterhead) that the applicant will use to conduct its business as a Utilization Review Agent pursuant to *452 CMR 6.00 et seq..*, which should include, but not be limited to, a **Letter of Introduction** that includes and introductory paragraph to the injured employee and a paragraph that outlines the utilization review complaint process that addresses complaints against the actions or inactions of UR Agents, information regarding ID card that should have been receive from the insurer/adjuster and if not received, who to call and telephone number to request the ID card; **Approved Determination** letter that includes introductory paragraph and HCSB guidelines/review criteria or secondary source(s) used to approve health care service(s); **Adverse Determination** letter that includes introductory paragraph, HCSB treatment guideline/review criteria or secondary source(s), clinical rationale, name and school of school to school reviewer and appeal/complaint process; **Adverse Determination letter upholding an initial adverse determination** that includes introductory paragraph, HCSB treatment guideline/review criteria or secondary source(s) clinical rationale, name and school of school to school reviewer and process to file for further appeal or to file a claim for payment with the DIA. **Approved Appeal** letter that includes introductory paragraph, HCSB treatment guidelines/review criteria or secondary source and clinical rationale. Other letters and forms to be included; Letter requesting additional medical information, form for referral to same school reviewer.

B. The Office of Health Policy requires the following paragraph be included in the body of all mandated introductory letters to injured workers in accordance with 452 CMR 6.00 *et seq*.:

> If at any time an injured employee, ordering provider, or employee representative believes the utilization review agent's conduct to be in violation of the Code of Massachusetts Regulations, 452 CMR 6.00 *et seq*., a complaint may be filed with the Department of Industrial Accidents by contacting the Department by phone at (617) 727-4900 x438 and requesting a UR agent complaint form (133A). A copy of this form is posted on the Department's website at www.dia.state.ma.us.

V. REVIEWER CREDENTIALING PROCESS

Exhibit I

A. Provide a detailed description in narrative form of the applicant's credentialing/re-credentialing procedures for its medical director and/or clinical director, school to school reviewers, registered nurses, and all other clinical reviewers that includes, but is not limited to, credentialing/re-credentialing procedures that ensure that all clinical review staff are properly qualified and credentialed to provide clinical opinions, board certification (if applicable), and a description of both the initial and on-going process for verification of the credentials of the applicant's reviewers.

B. Provide job descriptions for all employees performing non-licensed administrative functions for the utilization management department.

C. List of reviewers conducting reviewers at all levels of the review. List the name, license category and registration number/board certification number and state of licensure for each reviewer conducting any level of review, including the medical director.

D. Provide job descriptions for the medical/clinical director who provides medical oversight for clinical reviews. The medical director’s job description should include licensure and board certification requirements.

E. Job descriptions for all levels of clinical reviewers that indicates the clinical reviewer will be in active practice at least 8 hours per week, and includes level of licensure.

F. If any part of the applicant's credentialing/re-credentialing procedures is subcontracted the applicant should provide a description of the applicant's procedure for monitoring of the sub-contractor's credentialing procedures which may include, but is not limited to, policies and procedures that provide for periodic review of the sub-contractor's performance, and copies of the sub-contractor's credentialing procedures.

VI. TELEPHONE SYSTEM

A. Indicate the days and hours (EST) of operation during which the applicant's reviewers will be available to perform Utilization Review: Must be at least 9am - 5pm EST.

HOURS

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Exhibit J
Describe the applicant's system for receipt of telephone calls and messages during non-business hours. This line must be confidential line within the UR department.

Exhibit K
Describe the applicant's toll-free telephone script(s) - including holidays, weekends and non-business hours, automated call distribution greetings, recorded messages, and/or live script(s) specific to the Program.

VII. GENERAL REQUIREMENTS

Exhibit L
A. Include the applicant's written policies and procedures for assuring the confidentiality of injured worker specific information obtained during the Utilization Review process.

B. Does the applicant have professional and general liability coverage at limits of not less than one million dollars per occurrence?

☐ Yes ☐ No - Explain

Exhibit M
List all Insurers with whom the applicant contracts with.

Exhibit N
List all entities with whom the applicant will sub-contract for the provision of some portion(s) of the applicant's Program and provide a detailed narrative description of the Program's monitoring procedures for the oversight of sub-contractors.

VIII. CERTIFICATION

By the signature of the authorized representative below, the applicant certifies it has read and understands 452 CMR 6.00 *et seq*. and shall comply with all applicable Massachusetts and Federal Laws, including, but not limited to, those laws which protect the confidentiality of medical records. In addition, the undersigned certifies that all other information provided with this application is neither falsified nor fraudulent.

BY:

Name of Applicant: _____ Date: _____

Name/Title of Authorized Representative: _____

_____

Signature of Authorized Representative: _____